2015 BENEFITS SUMMARY COMPARISON

SEE THE PLAN DOCUMENT FOR A FULL DESCRIPTION OF BENEFITS.

You can access the Plan Document through Employee Connect or FBC Website.

In the event any benefit summary contained herein differs from the official text of the Plan, the official text shall prevail.

NOTE: Health Care benefits are subject to change to be compliant with the Health Care Reform Legislation.

NEW EMPLOYEES: Benefits are effective the 1st of the month following 58 days of continuous Active Service.

LATE ENTRANTS: Benefits are effective the 1st of the month following 58 days upon receipt and approval of Late Entrant documentation.

SPOUSAL COVERAGE: Employee's spouse needs to enroll in their employer's medical plan, if eligible, to be eligible for secondary coverage under the Fort Bend County Employee Benefit Medical Plan.

MEDICAL PLAN:	*FBC Employee Benefit Plan Option A (PPO)*		*FBC Employee Benefit Plan Option B (PPO)*	
	PARTICIPANT'S COINSURANCE PERCENTAGE SHOWN UNLESS OTHERWISE NOTED			
	In Network	**Out of Network**	**In Network**	**Out of Network**
CYD* Per Participant	$300	$700	$850	$1,000
CYD* Annual Family Limit	$300 X 5 = $1,500	$700 X 5 = $3,500	$850 X 3 = $2,550	$1,000 X 3 = $3,000
Participant's Coinsurance* Per Participant Maximum Annual Family Maximum	20% $3,800 X 5 = $19,000	Maximum Eligible Charge****	20% $2,500 X 3 = $7,500	Maximum Eligible Charge****
Plan Pays 100% Coinsurance, if not covered by Other Group Health Plan, When Qualified & Eligible Expenses Reach	$19,000	$20,000	$12,500	$15,000
Office Visit Copay (Physician's Charges Only)**	$30	50%	$30	50%
Annual Wellness Benefit***	$750	None	$750	None
Annual Vision Benefit Not Covered: Refraction Fee, Glasses, Contacts, and Other Exclusions**	20%***	50%****	20%***	50%****
Hospitalization - Inpatient*	20%	50% Plus $250 Per Hospital Confinement	20%	50% Plus $500 Per Hospital Confinement
Hospitalization - Outpatient*	20%	50%****	20%	50%****
Surgery - Inpatient*	20%	50%****	20%	50%****
Surgery - Outpatient*	20%	30%****	20%	30%****
Emergency Room	20%	50%****	20%	50%****
Emergency Room* (Non-Emergency Visit)	20%	50%****	20%	50%****
PREMIUMS	**FBCEB Plan A - 24 Payroll Deductions Per Year**		**FBCEB Plan B - 24 Payroll Deductions Per Year**	
Employee Only	**$30.54**		**$5.01**	
EE and Child(ren)	**$84.64**		**$30.90**	
EE and Spouse	**$138.95**		**$56.78**	
EE and Family	**$193.06**		**$82.67**	

*Subject to Calendar Year Deductible (CYD) ** OV Copay Extends Beyond Satisfaction of Calendar Year Deductible *** Subject to Office Visit Copay
**** See Plan Document for Details ***** Over Maximum is Processed under Medical, Subject to CYD and Coinsurance

	RETAIL PHARMACY (30 Day Supply or Less)	**MAIL ORDER PHARMACY (90 Day Supply)**
Tier 1 Generic	**$12**	**$24**
Tier 2 Brand Name	**$30**	**$60**
Tier 3 Non-Formulary	**$50**	**$100**
Tier 4 Specialty	**$125**	**$250**

DENTAL PLAN:	*FBC Employee Benefit Plan*	*CompDent (DHMO)*	
	Any Licensed Dentist in the U.S.A.	**In Network**	**Out of Network**
CYD* Per Participant	$100	None	None
CYD* Per Family	$300	None	None
Co-Insurance	Type I Benefit Must Be Used First / Type II and V Services Plan Pays 80% / Type III and IV Services Plan Pays 50%	See Plan Schedule in Benefit Booklet for Co-Pays	None
Preventative Benefit	Type I Services 100% / Required Every 180 Days	See Plan Schedule in Benefit Booklet	None
Calendar Year Maximum Per Person	$1,500	See Plan Schedule in Benefit Booklet	None
PREMIUMS	**FBCEB Dental Plan - 24 Payroll Deductions Per Year**	**CompDent - 24 Payroll Deductions Per Year**	
Employee Only	**-0-**	**-0-**	
EE and Child(ren)	**$17.93**	**$10.66**	
EE and Spouse	**$11.16**	**$10.00**	
EE and Family	**$29.09**	**$14.92**	

VISION PLAN:	*VisionCare*
	See the Plan Summary for benefits.
PREMIUMS	**VisionCare - 24 Payroll Deductions Per Year**
Employee Only	**$3.46**
EE and Child(ren)	**$6.55**
EE and Spouse	**$6.90**
EE and Family	**$11.59**